Intermountain®
Primary Children's Hospital
Behavioral Health

Pre-visit Paperwork

Today's Date: _____ Patient's Name _____ Date of Birth_____

Completed by _____ Relationship to child: ☐ Parent ☐ Self ☐ Other _

Doctor or Therapist's Name: _____ Child's Primary Care Provider: _____

1. What are your main concerns for the visit? What are the presenting symptoms?

_____

_____

2. What are you hoping to accomplish during the visit?

_____

_____

3. List any current medication your child is taking.

Name of Medication	Dosage in mg (from pill bottle)	How often?	Side effects

4. Has your child been treated or evaluated for mental health problems in the past?

Approximate date	Type of treatment or evaluation	Did it help?

5. List any psychiatric medications that your child has taken in the past.

Name of Medication	Dosage in mg (from pill bottle)	How often?	Side effects

6. Does your child have any ongoing medical problems? If so, please describe.

_____

7. Is your child currently in any pain? If so, please rate 1-10 _____

0	1	2	3	4	5	6	7	8	9	10
No pain	Hardly notice pain It's more like minor discomfort	Slightly aware of pain But mostly don't think about it	Somewhat aware of pain Easy to take mind off it Doesn't get in the way of doing things	Quite aware of pain Not as easy to take mind off it	Very aware of pain May get in the way of doing things Hard to sleep or rest	Hard to take mind off pain Hard to find a comfortable position	Restless, fidgety Can't take mind off pain Can't find a comfortable position	Don't want to talk with people or text Don't want to eat Can hardly sleep or rest	Very hard to talk with people or text Pain is all you can think about Sometimes cry out	Not at all able to talk with people or text Not at all able to eat, sleep or rest May cry out uncontrollably

8. Who does your child live with?

Household 1			Household 2 (if needed)		
First Name	Relationship to child	Age	First Name	Relationship to child	Age

Does your child live with both parents? _____

If parents separated, how is time spent between houses? _____

9. What is your child's current grade level? _____ Name of school: _____

Does your child receive special services, have an IEP, or 504 plan at school? If so, please describe.

_____

_____

10. Does your child have any biological relatives who have behavioral, emotional, or mental problems such as depression, anxiety, bipolar disorder, ADHD, drug or alcohol use disorder, or suicide? If yes, please list below.

Relative (parent, sibling, etc)	**Behavioral, emotional, or mental problem**

11. Were there any problems during pregnancy or delivery with this child? If yes, please describe.

_____

_____

12. Describe your child's developmental history.

Please indicate, to the best of your memory if the ages for the following childhood milestones were **Delayed**, **Normal**, or **Early**.

For Infants, Toddlers and Preschool		
Behavior	Normal Development	Your Child's Development
Babbling	(4-11months)	☐ D ☐ N ☐ E
Walks	(11-14 months)	☐ D ☐ N ☐ E
First words	(11-15 months)	☐ D ☐ N ☐ E
Pretend Play	(12-24 months)	☐ D ☐ N ☐ E
Toilet Trained	(20-36 months)	☐ D ☐ N ☐ E
Speaks in full sentences	(2-3 years)	☐ D ☐ N ☐ E
Rides tricycle	(2-3 years)	☐ D ☐ N ☐ E
Plays socially with friends	(4-6 years)	☐ D ☐ N ☐ E
Writes letters and numbers	(4-6 years)	☐ D ☐ N ☐ E

13. Did your child receive any early intervention services? If so, please describe.

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_____

15. Has your child been exposed to anything **violent,** or **very scary,** or **upsetting**? If yes, please describe.

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